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PARLIAMENT OF TASMANIA

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PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS

# Flinders Island Multipurpose Centre Redevelopment

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*Presented to His Excellency the Governor pursuant to the provisions of the Public Works Committee Act 1914.*

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## MEMBERS OF THE COMMITTEE

Legislative Council

Mr *Harriss* (Chairman)  
Mr *Hall*

House of Assembly

Mr *Booth*  
Mr *Brooks*  
Ms *White*

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## **Introduction**

To His Excellency the Honourable Peter George Underwood, Officer of the Order of Australia, Governor in and over the State of Tasmania and its Dependencies in the Commonwealth of Australia.

MAY IT PLEASE YOUR EXCELLENCY

The Committee has investigated the following proposal: -

### **Flinders Island Multipurpose Centre Redevelopment**

and now has the honour to present the Report to Your Excellency in accordance with the *Public Works Committee Act 1914*.

## **1. BACKGROUND**

The Flinders Island Multipurpose Centre project provides for the redevelopment of the existing centre which is dated, inefficient and does not meet modern community health standards. The Department of Health and Human Services submission states that the aim is to provide a combined hospital/community health service centre which ensures the future of the various community health services and enables improved functionality of the hospital's acute, residential sections. The submission outlines the need for a new multipurpose centre on Flinders Island and the processes undertaken by the project team to achieve the optimum design for a centre which when completed will provide for improved health services delivery for the island community. It affirms that the project is consistent with Tasmania's Health Plan and assures the Committee that the planning and the approach taken will deliver flexibility in service delivery and value for money. The following is the main text of the submission.

## **2. PROJECT DEFINITION**

### **2.1 Primary Objectives**

The redevelopment of the Flinders Island Multipurpose Centre is to provide a combined hospital/community health services site. Implementation and completion of the project will provide hospital and community health services with a facility that improves functionality, amenity and ensures long-term sustainability with enhanced capacity for expansion of the various health services delivered to the local community.

The acute wing will have sufficient flexibility in its layout/design to cater for future expansion needs due to changes in service provisions and/or community needs.

The redevelopment will provide appropriate facilities to enable rural health practitioners to carry out their work at the Flinders Island Multipurpose Centre in an appropriate environment with adequate facilities in compliance with accreditation standards.

## **2.2 General Scope**

The scope of the work planned entails redevelopment of the existing Hospital to a modern 14 bed combined aged care, acute care and community health services centre.

The facility will incorporate single patient rooms with ensuite facilities that capture all day sun and maximise outlook. The redevelopment provides for 4 acute care beds, 5 low aged care and 4 high aged care and 1 extra room. All of the inpatient/residential areas will be new build with direct access to secured garden areas.

The primary health areas will be developed to a modern community health centre that includes GP consulting and treatment rooms, dental surgeries, and consulting rooms for visiting specialists and allied health services.

Community meeting/activities areas will have their own entry which enables separation from the health care elements allowing after hours use without impacting on inpatient care or activities.

The work will also include the relocation of the kitchen, the accident and emergency area and diagnostic and therapy services. Site works will enhance access to improve parking and maximise the amenity of the grounds for the use of patients and staff.

The proposed improvements and relocation of the hotel services areas of the hospital are required to improve the safety of patients and staff, and to allow the facility to provide contemporary delivery of acute, aged and community health services. Major issues are present with the dysfunctional location of key acute health service areas in this facility. The health services staff are unable to provide effective and safe attendance on patients in all areas.

Improving and expanding the areas for delivery of acute and community health care services is essential for the sustainability of this facility and for the island community that has this facility as the base of healthcare services.

Improvements and expansion of accommodation will generally be achieved through consolidation of existing usage and demolition, new build and selected re-use of the existing building.

## **3. NEED FOR THE PROJECT**

### **3.1 Changing Community Health Needs**

Throughout Australia significant changes are occurring which are particularly affecting the priorities for rural health and community services. These changes are needed to ensure that services meet current requirements and that they are favourably based to respond to a changing environment rather than rely on past expectations and experiences.

Area Health Services are responsible for coordinating the provision of aged care, inpatient and community health services in Tasmania. These services are generally delivered from rural hospitals, multi purpose services/centres and community health centres. There is a state-wide governance structure for the Department of Health and Human Services with health services managed through three Areas: the south, north and north-west. Flinders Island is located within and is the responsibility of Northern Area Health Services.

### 3.2 Strategic Direction of Rural Health

In 1999 the Australian Health Ministers commended and endorsed Healthy Horizons: A Framework for Improving the Health of Rural, Regional and Remote Australians. The purpose of this Framework is to provide direction for Commonwealth, State and Territory Governments in developing strategies and allocating resources to improve the health and well being of people in rural, regional and remote Australia. The Framework also provides guidance for communities and organisations for action to improve the health and well being of people living in rural, regional and remote areas.

During 2000 and 2001 the Department's Asset Management Services Branch coordinated a project called 'The Network Project' with the cooperation of the various Divisions responsible for providing and coordinating primary health services in the urban and rural communities. The Network Project aimed to consolidate the dispersed primary health services onto key, multiple-service delivery sites in order to achieve the following benefits:

- Opportunities for greater efficiency (sharing support facilities, etc.);
- "Cross-fertilisation" between related and compatible services, for the benefit of clients;
- Improved asset utilization;
- Asset change on those sites, to address issues of matching service need and responding to service change;
- Integrated and achievable management regimes for facility maintenance and operation, within the context of life cycle planning; and
- Integration with other services and like opportunities, in each case from a total site perspective. Client amenity is a key driver in this regard as is the ability to integrate various services that a single client may need to access and improve individual case management.

The Network Project prioritised all the key sites for service delivery and asset performance analysis and the redevelopment of the Flinders Island Multipurpose Centre was identified as a high priority.

The development of integrated facilities, like that at Flinders Island MPC, is totally consistent with the achievement of the goals of the Healthy Horizons Framework, particularly Goal 4: Develop flexible and coordinated services.

*Tasmania Together* is seen as a framework for setting government policy priorities, including the allocation of resources to those priorities, and will identify where service delivery can be improved. Flinders Island Multipurpose Centre redevelopment is to improve the services provided to the community and the aims underpinning them are consistent with government policy, the Agency's Business Plan and Strategic Positioning Document. The Flinders Island Multipurpose Centre redevelopment will aim to provide a community friendly facility with the potential to develop an approach to health and wellbeing that focuses on preventing poor health and encouraging healthy lifestyles and activities that engender a sense of community and encourage participation and involvement consistent with Goal 5: *Improve Tasmanian's health through promotion of a comprehensive approach to a healthy lifestyle*; and Goal 6: *To improve the health and wellbeing of the Tasmanian community through the delivery of coordinated services.*

In 2007 The Tasmania's Health Plan with supporting plans – *the Clinical Services Plan for Tasmania* and the *Primary Health Services Plan* were developed in support of the whole of Government 20 year plan *Tasmania Together*. The *Primary Health Services Plan* promotes the primary health approach with a focus on health and wellbeing not just illness; a multidisciplinary team approach to care; health promotion activities working with key stakeholders and local community to design and implement programs to support healthy life conditions and choices. The changing and expanded role of rural health facilities is to ensure the services better meet the needs of the Tasmanian population and their local communities; such as increased access to visiting services including allied and mental health services. The *Primary Health Services Plan* aims to improve relationships with General Practice to provide additional capacity to respond to the challenges of chronic disease, working together in the prevention and management of chronic disease and health promotion.

### **3.3 Existing Facility and Services at Flinders**

Flinders Island Multipurpose Centre has evolved over a period of time from a bush nursing centre to its present configuration as a Multipurpose Centre with the last significant addition to the centre occurring in the early nineties with the construction of the aged care wing. The building is a single story brick construction on two differing levels connected by a ramp. The lower level of the building accommodates General Practitioners Consulting Rooms, Dental clinic and other Primary Health and Community Services. The upper level accommodates Administration, Inpatient Services, Emergency room and Hotel Services.

The internal layout of the building does not provide functional working units for the multitude of services now scattered throughout the facility. The facility fails to meet a number of best practice health service delivery and safety standards necessary for provision and care of in-patient, residential aged care and primary health services.

The Flinders Island Multipurpose Centre facility does not meet contemporary occupational health and safety requirements for staff or clients in both the current acute and aged care sections; examples of this include bathrooms which are too small for assisted showering, lack of ensuites in aged care rooms, the lack of disability accessible toilets in the expanding community service area and confidentiality issues with sound proofing in the General Practice consulting rooms, limited access to meeting and consulting rooms.

The Centre presently has 4 acute beds, 9 aged care beds and provides accident and emergency treatment, ambulance, physiotherapy, diversional therapist, occupational therapist, podiatry, community health services, radiology, and other visiting services.

Flinders Island Multipurpose Centre is situated on a large site conveniently located close to the main centre of Whitemark township and adjacent to the perimeter of the Whitemark shopping centre and opposite the local government chambers. The location provides ready access for the public arriving by foot or private transport. There is one private medical practice in the town located in the Centre. The population catchment area for Flinders Island equates to some 800 persons, with the hospital located an hours flight from Launceston and the Launceston General Hospital.

The Multipurpose Centre also provides the base for provision of visiting services to Cape Barren Island the most regular of which is the medical service provided by the Flinders general practitioner.

Flinders Island is an isolated rural community with diverse industries that include beef, dairy, sheep farming, forestry, fishing, with annual mutton bird season activities and tourism. The Furneaux Islands are recognised as having one of the larger populations groups of Indigenous people in Tasmania.

The overall aim of this redevelopment project is to provide a new and integrated facility that combines the functions of a hospital, residential care, community health and primary health services that contributes to the community in improvement of health and wellbeing through the delivery of coordinated services.

This project will see the redevelopment of the existing centre to enable the provision of comprehensive, accessible and integrated services to individuals and the island communities within the catchment area. High priority should be given to the specific problems facing all rural communities including Flinders and Cape Barren Island caused by their isolation, the fragmentation of services and access to essential services.

### **3.4 Limitations and Changes with Existing Facility**

#### **Summary of Required Project Outputs**

The original project proposal was prepared in April 2008 and project funding was approved in the 2008/09 budget round for expenditure during the financial years of 2009/10, 2010/11.

As health care standards and the needs of the community have continued to evolve since the initial project proposal, the project requirements were reviewed prior to the engagement of the Architect and further refined through the design process.

In essence the original required project outputs have been refined with further required outputs identified during the stakeholder community consultation, master planning and schematic design stages.

The Project Team used the information gathered regarding stakeholder priorities to review the preliminary designs. The final design maximises 'value for money' by achieving the 'essential' and 'important' improvements required by the acute, aged care and community services section of the hospital. This approach has distilled the project outputs on a priority basis and these needs are addressed by the current design.

In accommodating all the required project outcomes decisions had to be made relative to design, architectural components, building fabric and fittings to maximise value and achieve savings to actively manage the budget.

The project will provide a clear demonstration of the State Government's commitment to retaining and further enhancing health services in Tasmania's most remote communities, in accordance with Tasmania's Health Plan.

The project will enable the development of contemporary facilities which will provide a standard of amenity that meets community expectations and all relevant standards.

Cost savings and efficiencies will be recognised through:

- improved working conditions and the resultant capacity to recruit and retain staff;
- reduced clinical and occupational health and safety risks resulting from sub-standard or poorly maintained infrastructure;

- reduction in on-going maintenance and energy costs; and
- Improved capacity to meet residential aged care certification requirements and maximize Australian Government revenue.

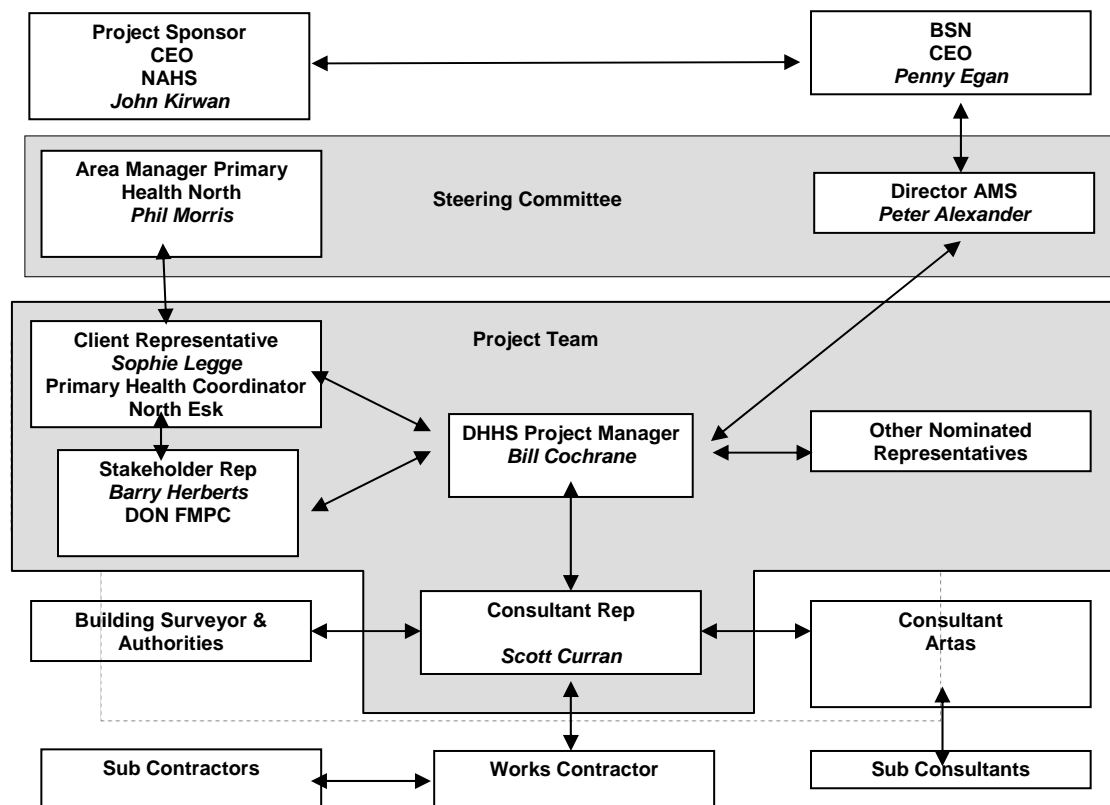
### Preliminary Consultation

The original project brief was prepared in 2001 through the Department’s ‘Network Project’ in consultation with of the various Divisions responsible for providing and coordinating primary health and community services. This project brief was reviewed and updated in 2009 in consultation with representatives from the Flinders Island MPC, Primary Health, Allied Health practitioners other departmental and community stakeholders including the local General Practitioners, Council, Aboriginal groups, auxiliary and community members.

### Project Coordination Group

Detailed stakeholder consultation commenced immediately following appointment of the Project Architects, Artas represented by Scott Curran. The following diagram illustrates the Steering Committee, Project Control Group and consultant team relationships.

## 4. PROJECT COORDINATION STRUCTURE



The Project Steering Group have been meeting as required to enable the project to evolve in line with the project timeline, the aim being to enable an adequate consultation phase while still allowing sufficient periods for documentation and procurement of the project.



This approach was identified during the initial consultation phase to maintain the project momentum to effect tendering of the project in second half 2010. The tender date is based on working back from the desired completion date of December 2011.

### **Consultation with Onsite Stakeholders**

In addition to representation on the Project Control Group through the Stakeholder Representative (Barry Herberts, Director of Nursing Flinders Island MPC), consultation and information sessions were held with onsite staff, general practitioners and visiting services and community members. Preliminary plans have been displayed onsite and further information sessions have been held.

### **Design Review**

Consultation with the stakeholders culminated in the development of the final agreed schematic design. A number of design options were tabled, discussed and then a system of prioritisation undertaken to ensure the maximum delivery of outcomes of highest priority within the available budget. The project team tested the options for adequacy in planning, design and budget and maximising value by improving the relationship between various services and related functions.

During the review process key stakeholders identified and analysed risks associated with the design changes, as they affected the service profile and/or changing the physical scope and layout of the proposed building without impacting on the main objectives of the project.

This consultative approach has resulted in a design that allows the desired outcomes to be delivered and forms a strong platform for any future development.

## **5. ADDRESSING THE NEED**

### **Flinders Island Multipurpose Centre Redevelopment**

#### **Existing Building**

The existing building is located on the corner of Davies and James Street, Whitemark. It was originally built in 1959 and extended in 1995. The construction is a combination of different types:

Floors	- Concrete slab and suspended timber
Walls	- Concrete block, timber with plasterboard lining
Windows	- Aluminium and timber
Ceilings	- Timber framed with plasterboard or cement sheet lining
Roof	- Traditional framed timber with corrugated roofing iron

#### **Limitations of the existing facility**

The existing building currently operates on two levels connected by a series of ramps.

The Allied Health Services, GPs, Dentist, Pharmacy, Specialist areas, Community Health and the Multi-Purpose room are located on the lower level, whilst Reception, Aged Care, Acute Care, Kitchen, Laundry and Accident / Emergency are located on the upper level.

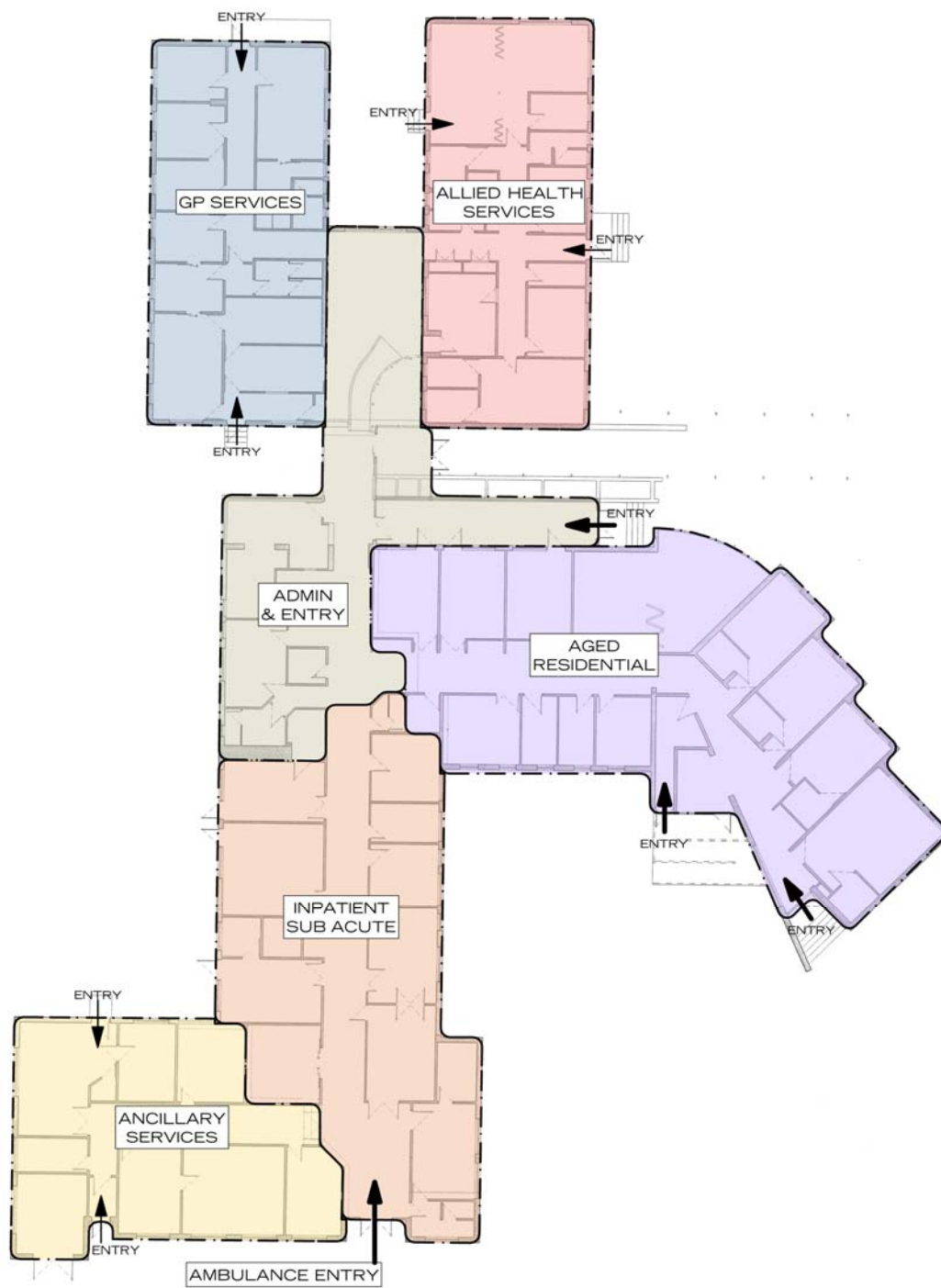
The number of access points distributed throughout the facility makes servicing the building out of hours difficult and time consuming.

Monitoring of patients and visitors is difficult due to the number of different access points.

The main entrance is not easily identifiable and creates confusion upon arrival.

The condition of the entry canopy is poor and requires replacement.

## Current Zones



EXISTING FLOOR PLAN  
1:300

## **Aged Residential**

This area provides accommodation for five high care and four low care residential aged care beds. In addition to the four ensuite bedrooms, this area comprises dining, lounge room, laundry, kitchenette, sitting room, two nursing bathroom areas, one high care nursing bathroom, cleaner's area, visitor toilet and three nursing rooms.

The existing aged care area is contained in a single wing. The rooms are a combination of the original building and an extension completed in 1995.

The original rooms are dark, have no ensuites and no ventilation.

The newer rooms are severely constrained in that the ensuites are small and do not comply with current regulations, the windows are small and do not enhance the outlook.

Access to the garden is via a complex ramp, circulation spaces and service areas which are small and require refurbishment.

The common areas are small which makes manoeuvring lifting machines and other pieces of equipment difficult.

## **Inpatient Sub Acute**

This area provides two, two bed wards with ensuites, an accident and emergency room, acute patient lounge, treatment room and other utility rooms necessary for acute patient care.

Inpatient Sub Acute is situated in the original building and all rooms open off a busy and noisy corridor. The rooms are large with ensuites that do not comply with current regulations. The location of the Emergency Department, Treatment Room and Visitors' area all contribute noise and activity to this area.

## **Ambulance entry**

The current ambulance entry is located too far from the Emergency Treatment room. This area has issues with weather protection, narrow vehicular access and no automatic doors. After hours access and security need to be re-considered to provide a safe and manageable entry point.

The emergency treatment room and smaller treatment room are too small and require refurbishing.

The X-ray/Pathology room is also currently used as a store room. The room is small and a redesign of the area along with an equipment upgrade is recommended.

The pan room and prep sterilisation area require a redesign to improve functionality. An upgrade of fittings, fixtures and finishes in this area is required.

General Staff meeting and dining areas are extremely limited and small, thus restricting the opportunity for staff to participate in any meeting or education.

The condition of the original building is fair and requires extensive upgrading to achieve modern and efficient spaces.

## **Ancillary Services**

This area comprises the staff dining, kitchen, pantry/store, boiler room, laundry and linen store. The staff dining room is too small to service all staff and is in poor condition. The kitchen provides an average of thirty meals per day for

staff/patient/residents/Meals on Wheels. The capacity for large food storage is required in case the island becomes inaccessible – a separate freezer/cool-room area is required. It is recommended to redesign this area and upgrade the kitchen, equipment and storage facilities. The present location for delivery access is suitable.

The linen store currently serves as the main computer hub. The general condition of the laundry, dirty linen and linen store is poor.

### **GP Services**

Two GP's service Flinders Island (with a visiting service to Cape Barren Island) and operate out of this area. The GP service is provided by a private medical management company according to a contract with DHHS. The GPs also provide a pharmacy dispensing service.

In addition to the two consulting rooms there is a treatment room, pharmacy, reception and private toilet facilities.

The waiting room is dual purpose as it also services as the waiting room for the remainder of the Centre. A separate waiting room is required for the GP practice. The GP reception area provides no privacy for patients as it is located too close to the waiting area.

Current access to the GP Consulting Room is inappropriate. There is no privacy – sound proofing of the GP surgeries has been highlighted as an issue and there is no dedicated Practice Nurse space. This entire area requires a redesign, staff and patient security, privacy, access and acoustics needs to be considered. The Pharmacy area also requires an upgrade and an increase in size.

### **Allied Health Services**

This area provides consulting rooms for visiting allied health professionals and/or local staff, a multi- purpose room with Telehealth facilities and two bedrooms for staff accommodation as well as the Director of Nursing's office.

It is contained in a separate wing that appears to have been constructed and extended over a number of years. Access to this area is via an entry ramp. Whilst the condition of the building in this area is fair to reasonable the site and layout of the rooms leads to inefficiencies.

The corridor widths are too narrow, the fittings and fixtures require upgrading and the lack of acoustic privacy in all rooms is detrimental to patient confidentiality. The reception area, records, pharmacy and waiting areas are all undersized and additional area is required. The day centre is in good condition however is undersized and has no storage.

### **Administration and Entry**

This is the first point of contact into the building from the Main Entrance via an airlock and foyer. It comprises reception area, office, administration area, nursing station, Clinical Nurse Manager, toilet and switchboard room.

The entrance walkway leading to the Main Entrance is rusted and requires replacement. The airlock does not function properly and due to the location of the reception, is difficult to supervise out of normal hours. The foyer is narrow and the reception area is uninviting and cramped. The waiting area for the reception is

inappropriately located down a ramp. It has been recommended that this whole area be redesigned to improve efficiency.

### **The Current Structure**

The current structure and condition of the building makes modification difficult. The life cycle of the services, fixtures and fittings is nearing their maturation point. In addition to the considerations the following have also been carefully considered:

- Eaves: contain asbestos
- Fascia: rusting- requires repainting and replacement in some areas.
- Flat pitch of the roof is creating issues for wind driven rain
- Aluminium windows have degraded
- Timber window frames have rotted
- The majority of plumbing requires replacement
- Electrical switchboard requires upgrading
- Concrete is “blowing off”
- Metalwork is rusting generally

## 6. DESIGN PHILOSOPHY

The proposed redevelopment is a major refurbishment of the existing hospital.

The design philosophy has been to:

- Replace the facility to incorporate best practice contemporary health planning and also accommodate current efficient hospital operation practices;
- Provide an aesthetically pleasing building sympathetic to the existing streetscape with enhanced levels of amenity and comfort;
- Incorporate functional planning to accommodate shared resources between acute care and community services such as Accident and Emergency treatment suites, and medical imaging;
- Design for flexibility changing health care delivery into the future; and
- Design for staged development that takes into consideration that the hospital will remain in operation for the duration of the project.

## 7. PROPOSAL

The new building has been designed on one level with the main entry point off Davies Street. This was determined primarily for the level access. Another important consideration in determining this entry is the need to create a single main entry point to assist with security and after hour access.

In addition it was important that the doctors, specialist area and community areas be able to operate independently of the main building. This has been achieved with access to all of these areas directly off the visitor parking area.

### **Aged Residential**

The aged care section has been located to ensure rooms have good views, have good access to natural light and each has access to a balcony. Minimisation of travel distance from the nurses' station has also been carefully considered.

Access ensembles to comply with the current standard and overhead lifting tracks are included.

A small sitting room has been located in this area for families or visits that require a more private or quiet space.

A patient lounge and dining room provides flexibility of use in this area allowing small intimate groups or the area opens up to become a large communal area. Both spaces open directly onto courtyards to provide a link between the inside and outside.

Service areas such as cleaners store, pan rooms, dirty utility, clean linen and the assisted bath are located within this area to provide easy access and close proximity.

### **Inpatient Sub Acute**

The acute area is located close to the nurses' station and the emergency area. Four bedrooms have been provided with ensembles. Each room has good visual access to the garden facing north, as well as access to a balcony.

Access ensembles to comply with the current standard and overhead lifting tracks are included.

### **Ambulance entry / Emergency**

Ambulance entry is positioned to give a direct covered entry point to the resuscitation room, which is located centrally in the facility so as to be in close proximity to nurse's station and staff areas while allowing it to be operational after hours.

A flexible treatment room has been located adjacent to the resuscitation area to provide flexibility and to assist with busy periods or additional visiting specialists. Toilets are adjacent to the resuscitation space.

### **Ancillary Services**

Located centrally is the staff room which opens directly into the internal courtyard. The nurse's station has been positioned to enable sight down both main corridors and to act as a central point.

The kitchen/freezer/stores, office and laundry are separated by a double door effectively isolating this area.

A vehicular access to this area is via the service entry and provides easy access to deliveries and rubbish removal, as well as Meals on Wheels. The location of the kitchen adds convenience and cuts down travel distance for food deliveries to the aged care and acute areas.

The laundry has been located adjacent to the "hotel services" component to combine these functions within the same area.

The location of the morgue and viewing room has been an area of particular interest for all user groups. Current deficiencies with the location of the existing morgue have driven the determinants for the location of the new morgue.

This location has been determined based upon the following criteria:

- under cover access, close proximity to night staff, privacy, a discrete entry for the family and undertaker as well as flexibility.

### **GP Services**

The doctors and specialist area now have their own independent entry point enabling patients to access this area directly. Access is via an undercover entry and airlock that help control temperature and combat the high winds.

A reception integrated with fire-rated store, resource area and pharmacy makes this area independent. A centralised waiting area with sliding door ensures privacy for users when attending reception. Four GP consulting rooms add to the flexibility of this area. The dentist is also located in this zone.

### **Allied Health Services**

The Allied health and community zone has also been located so as to give discrete separation from the rest of the facility whilst still retaining a link.



The community meeting room, stores, tea making, lobby and toilets can all operate independently out of hours if required. The flexibility of this space adds greater overall flexibility to the operation of the centre.

Primary health, physio, podiatry and general rooms are also located in this zone. The reception located inside the main entry helps to guide and control visitors.

### **Administration and Entry**

Secure reception with resources room and fire isolated store located predominately in the main entry. The central reception allows staff to direct visitors to different parts of the facility.

### **General**

The X-ray has been positioned to enable it to be located between the acute area and the doctors and specialist area.

Storage areas and cupboards are distributed throughout the building to ensure items can be stored away from the spaces keeping them uncluttered and clean.

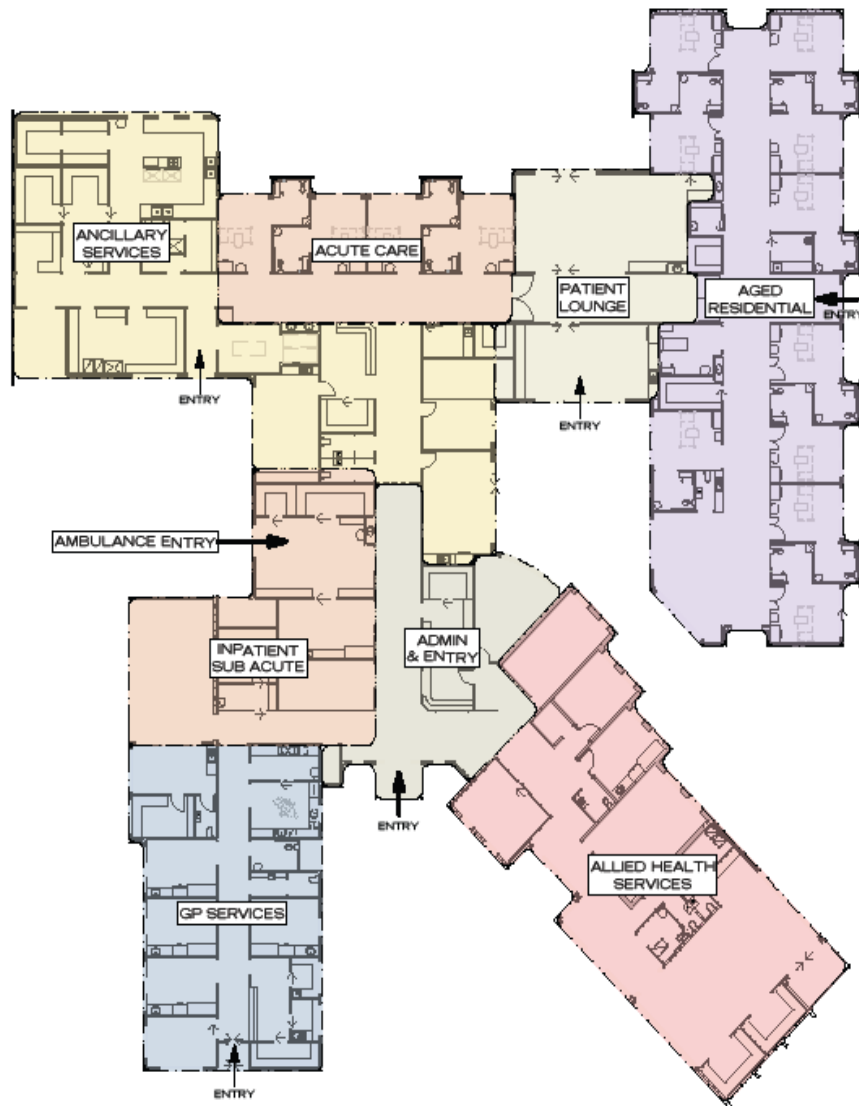
The courtyard is a sheltered space that enables staff and patients to sit outside whilst maintaining proximity for supervision and security. The finish to the courtyard is slip resistant and easy to maintain. Access to the garden is via an access ramp.

It is proposed to retain the existing landscaping and relocate the pergola to provide a secure garden area in the south east corner of the site. This area is flat and sunny and provides shelter from the westerly wind. It will be enclosed by a 1500mm high powder-coated pool type fence to ensure patients can be contained in this area.

Gardens and lawn areas will be developed around the site to provide an attractive feature that is easily maintained.

## Proposed Design

The following diagram details the design of the proposed facility and shows the zones for the location and relationship of the various services.



PROPOSED FLOOR PLAN  
1:300

## **Construction materials**

The primary structure will consist of concrete slabs and timber framed walls with timber trusses. Steel framing will be used in some areas to create smoke compartments in accordance with the Building Code.

External materials have been governed primarily by the harsh weather conditions experienced on the island. Strong winds blowing salt water and rain dictate the need for durable robust materials. Other contributing factors for material selection are maintenance requirements and the availability of delivery to the island.

The majority of the external being constructed by pre-cast concrete panels and Colourbond Ultra metal sheeting.

Pre-cast concrete is a durable material that can withstand salt water and high winds. The panels can be fabricated on site limiting the transportation requirements. The panels will have a mixture of water blasted faces, rebated shadow lines and coloured pigmentation to provide a variety of texture and colour to the façade of the building.

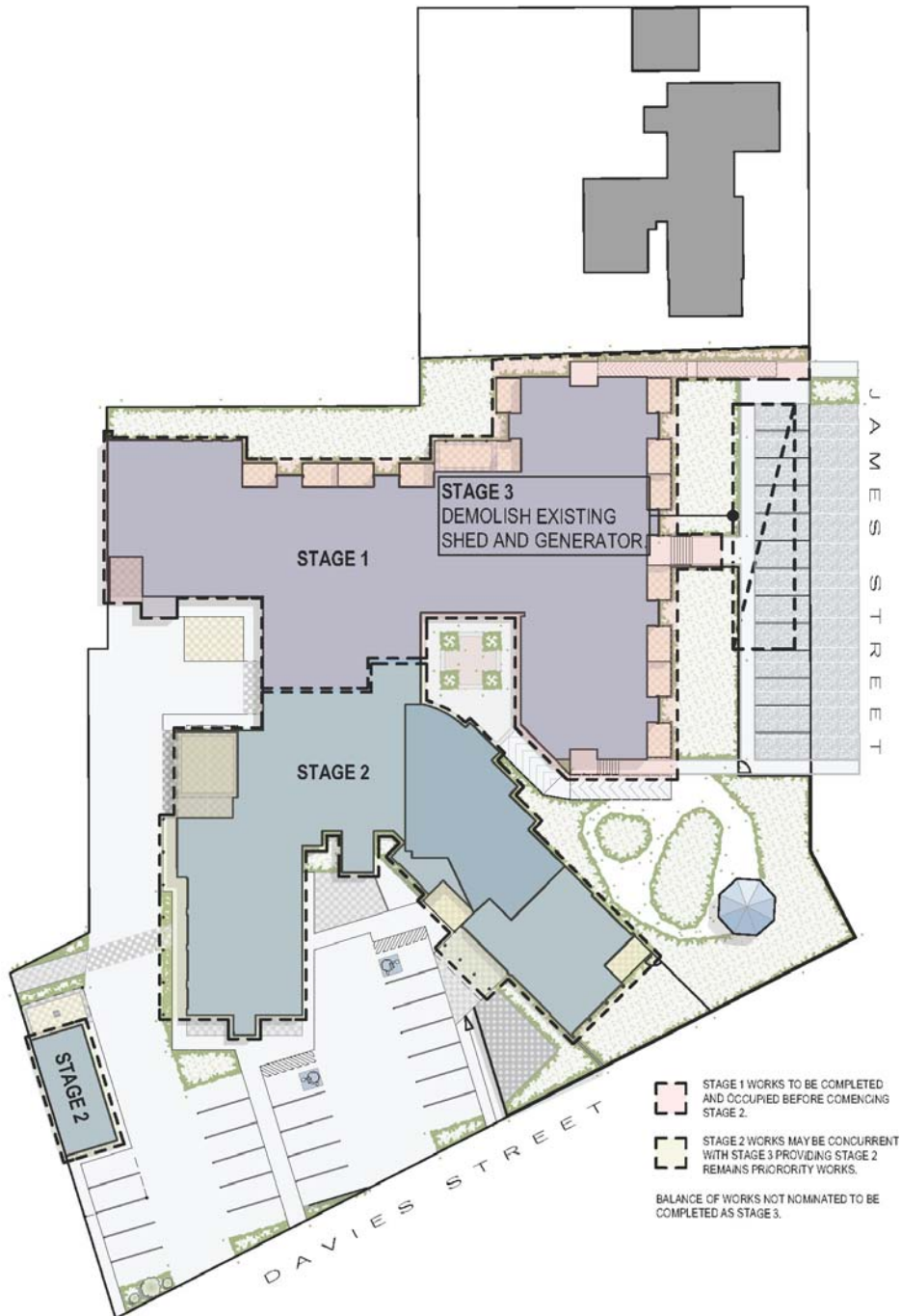
Marine grade Colourbond Ultra will be used in large parts for roof sheeting and flashings as well as for external cladding. The use of Colourbond above and below window openings allow for a lighter timber construction as opposed to the alternative concrete material. It also breaks down the large walls visually to help give the building a residential scale.

Aluminium window and door frames are to be used externally in preference over timber for durability against rotting. The aluminium is to be anodized rather than painted to withstand against the powdering and fading caused by salt water content in the rain.

Exposed steelwork will be kept to a minimal to help prevent corrosion. This will be achieved by concealing steel or by using galvanized or stainless steel in areas where exposed steel is unavoidable.

To ensure that the buildings floor level is consistent throughout, it will sit on a pre-cast concrete plinth. By providing a suspended slab on Bondek over this area it allows for services to be re-located if future alterations were required as well as providing a space for water tanks.

## 8. Project Staging



The project is to be split into three stages (shown in diagram attached) to allow for the facility to operate throughout the construction period.

## **Stage 1**

Stage 1 of construction is to consist of the demolition to the North of the existing reception area, and construction of Aged Care, Acute, Ancillary Facilities and all other areas north of the new resuscitation room. A temporary wall and cladding will need to be constructed across the point of connection to stage 2. The roof structure over this area is designed to allow it to be constructed in stages.

During this period, Allied Health and GP services will need to operate from off site.

## **Stage 2**

The works for stage 2 will include the remainder of the demolition works (excluding the existing maintenance shed) and the construction of the remainder of the building south of the resuscitation room.

The new maintenance shed is to be constructed during this stage and generator installed and ready to switch over upon removal of existing generator in stage 3.

During this time the aged care and acute patients can be moved into their new locations. Allied Health and GP services remain offsite. Emergency services will be required to operate from within the new acute rooms.

## **Stage 3**

The stage 3 works will be the balance of the works including landscaping and demolition of the existing maintenance shed.

## **Sustainability Features**

The building's orientation allows for the accommodation rooms to receive natural light throughout the day. In addition to this, the corridors and multi-purpose room receive natural light due to high level glazing.

The use of pre-cast concrete walls and in-situ concrete slabs, allow for the construction to occur on site saving cost and embodied energy associated with transportation of large items. These panels along with the Colourbond require low maintenance over time in terms of re-painting.

Tanks located below the suspended slab will collect rainwater for re-use in flushing toilets and irrigation for the landscaping.

The use of 10.3mm laminated glass to external windows and doors will reduce the heat loss through cold periods while with the addition of overhanging eaves will help keep the rooms cool during the hotter periods.

## **Sustainability Strategy**

The following sustainability strategies will either be incorporated as standard and best practice or be considered as effective measures of reducing the impact of the proposed systems on the environment via greenhouse gas emissions. Due to the remoteness of the site, any technology has to be weighed up against the requirement for maintenance and servicing.

## **Mechanical**

Energy reclamation, storage and alternative sourcing will all be considered such as geothermal.

### **Energy Sub-Metering**

Both electrically and to the various components of the Mechanical Services systems by way of flow, temperature and energy sensors, linked to a BMS system with reporting capabilities to target wasteful or faulty processes.

### **Peak Energy Demand Reduction**

Where hospital operations will not be compromised, shedding load to reduce the peak energy usage will involve relaxation of temperature control limits, temporary isolation of non-critical energy sources (coupled with increasing storage of energy).

Environmentally friendly refrigerants, insulation and other products. Systems with zero ODP and low GWP will be given priority in the design process. Refrigerant leak prevention, detection and recovery systems will be considered.

### **Indoor Environment Quality**

Many considerations will be incorporated as standard practice and requirements for BCA compliance, but plant efficiency, passive measures to increase quality and decrease energy usage, economy cycles and BMS control and monitoring will be considered. Increasing ventilation rates and effectiveness will also be considered in conjunction with the Department's requirements and energy targets.

Holistic approach to energy and waste management – the various services and the building envelope must be considered together, from the BCA point of view and for ESD purposes to maximise passive advantages and minimise the use of energy and resources.

### **Electrical**

The following sustainability strategies will either be incorporated as standard and best practice or be considered as effective measures of reducing the impact of the proposed systems on the environment.

Energy reclamation, storage and alternative sourcing will all be considered.

Intelligent artificial lighting controls to allow zoning and dimming of lighting via motion detection, photo-electric cell, time of day level control and setback levels for areas of sporadic usage will be incorporated.

Energy sub-metering with meters linked to the BMS system with reporting capabilities to target wasteful or faulty processes and improve long term energy reduction.

### **Peak energy demand reduction**

Power factor correction to be considered.

### **Indoor Environment Quality**

Many considerations will be incorporated as standard practice and requirements for BCA compliance but lighting efficiency and efficacy, passive measures to increase daylight quality and quantity and decrease energy usage will be considered.

Occupant comfort considerations such as high frequency lighting ballasts, artificial lighting levels and control systems will be reviewed.

Natural light glare control with use of fixed or automated blinds/louvres.

Minimisation of light spill (emissions) will be included in the design process.

Environmentally friendly and low toxicity materials such as the use of XLPE instead of PVC insulated cabling.

## **8. SERVICES**

### **Existing Services**

Building services are generally beyond their economic life and it is recommended they be replaced by energy efficient and low maintenance fittings and equipment.

Re-use potential includes the following that can be adapted to meet the staged nature of the redevelopment.

- Fire Detection system and Fire Panel
- Telephone system including DECT
- Communications racks and equipment
- Nurse Call system
- Some electrical sub-mains
- Intercom and CCTV cameras
- Air Conditioning units on site
- Wall mounted panel heaters where new
- Dental equipment and accessories
- Fire Hose Reels and Hydrants
- Sewage Treatment Plant
- Some hot water cylinders
- Kitchen exhaust hood
- Stand-by generator

### **Electrical Supply**

The facility is powered from a pole mounted Aurora transformer in the street.

The existing main switchboard will need to be replaced.

New loading requirements will be ascertained during the design development phase.

Electrical services will include new sub-mains, switchboards and distribution boards, circuit protection and general lighting, power and heating in all areas.

The existing stand-by generator can be re-used subject to new loading requirements. Load shedding will be undertaken if necessary.

### **Communications**

The existing facility is a hub for inter island communications that will need to be carefully managed to maintain required services.

In addition, there are existing Telehealth, Rural Health, Ambulance, Radio and Satellite telephone services.

The existing telephone system can be re-used but reticulated over a new integrated voice and data network to DHHS IT standards (Category 6) throughout the new facility. Use of wireless technology will also be facilitated.

### **Security**

Staff and patient security will be managed by:

- Access control to key building entry points.
- An upgraded CCTV system and monitoring from any connection to the DHHS wide Area Network.
- All external doors monitored for opening via the Nurse Call system.
- Intercommunication improved for staff by additional DECT handsets with full coverage of the site.
- Lighting to external areas and car park.

### **Fire Detection Services**

The existing Fire Detection system will be re-used and upgraded to a full Smoke Detection system and Electronic Warning system.

To be interfaced to the Nurse Call/DECT system.

### **Mechanical Services**

New works will have compliant exhaust systems etc as required. Dependant on budget and spatial allowances, selected spaces will be air conditioned by air conditioning systems. The primary form of ventilation (outside air) will be by ducted tempered systems. Natural ventilation will be utilized where possible in all areas. Generally, heating to be by ceiling mounted panel radiators and re-used wall mounted radiators.

Several reverse cycle split system air conditioning units have been retrofitted to the facility and re-use of these systems will be undertaken.

The kitchen hood will be considered for re-use but it may not be practical based on maintaining food service provision at all times and the staging requirements.

As with lighting, the areas of similar usage patterns will be zoned for operating times and temperature control. The intent is to minimise energy usage when areas are not occupied. With heating, this would be a combination of time scheduling and after-hours push buttons and timed operation.

### **Hydraulic Services**

#### **Water Supplies**

Town water is utilized for fire fighting and laundry. Recycled water will be utilized for water flushing and irrigation purposes. Potable water is sourced from capture of rainfall into 20,000 gallon in-ground tanks, followed by UV treatment. Reserve capacity is held in an above-ground tank adjacent the Sewage Plant. This system will be relocated and upgraded as part of the Contract works.



## Sewage Treatment

All the facilities sewer collection is pumped to a new sewage treatment plant across the street from the site. This plant is owned and maintained by the facility but there are some residential connections from adjacent properties that will need to be maintained during the construction period.

Grease traps will need to be replaced with new to facilitate staging.

## Fire Fighting

External Hydrants and Hose Reels will be re-used with some relocation required.

Hot water heating is via several banks of electric storage heaters, some of which could be re-used. Further study will be undertaken into reverse cycle central or distributed plant plus solar.

## 9. PROJECT SCHEDULE

### Summary of Project Timeline

Project Stage	anticipated completion date
Schematic design	August 2010
Design and Documentation	December 2010
Works Tender Advertisement	29 January 2011
Contract Award	14 March 2011
Construction Commencement	4 April 2011
Construction Completion – All Stages	28 September 2012
Occupation and clean site Clean up	15 October 2012

The Construction Phase comprises three stages, and the anticipated timeframe for the staging is:-

### Staging Programme

Construction start April 2011	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O
Stage 1																			
Stage 2																			
Stage 3																			

## 10. PROJECT COST

The approved funding for the redevelopment is \$6,000,000.

The cost of the redevelopment is currently:

Construction costs	\$5,332,000
Site Works	\$200,000
Construction Contingency	\$300,000
Professional Fees	\$450,000
Art in Public Building	\$80,000
Escalation Costs	\$180,000
Equipment	\$100,000
<b>Project Total</b>	<b>\$6,642,000</b>
Budget Shortfall	-\$664,200

The above budget for the redevelopment indicates a funding shortfall of approximately \$650,000. This outcome is subsequent to rigorous design and value management review process. The cost increase is due to ongoing cost escalation in the building industry, inflation, locality allowance and is not a result of scope creep or over design. The remote location with the current high levels of activity in the construction industry has markedly increased the level of the locality allowance as builders are able to achieve a good level of profitability for projects in the metropolitan areas without the complication of undertaking work in a remote area with logistical challenges.

There is currently no readily identifiable source of funds to cover the project shortfall but the delay to the project pushes out the final funding requirement to the 2011/12 financial year. However; the project team has developed strategies to fund the shortfall and it is anticipated that additional funds will be identified by this time.

The current project costs are provided by the project Quantity Surveyor and based on reasonable allowances for the remoteness of the job, current market conditions and the ability of the contractor to engage subcontractors in a remote location.

## 11. RECOMMENDATIONS

The Project Steering Committee and Project Team have carefully assessed and explored the options and solutions available and have determined that the design submitted provides the required project outputs as determined in the project functional brief. In addition, the design is consistent with the strategic long-term direction proposed for the site.

It is recommended that this submission be viewed favourably and in the spirit of the benefit it will provide to this isolated rural community. The proposed works will

immediately address the high priority outputs the facility requires to deliver appropriate health and community services.

## 12. DOCUMENTS TAKEN INTO EVIDENCE

The following document was taken into evidence and considered by the Committee:

- Department of Health and Human Services, Submission to the Parliamentary Standing Committee on Public Works
- Department of Health and Human Services, Amended Submission to the Parliamentary Standing Committee on Public Works

## 13. EVIDENCE

The Committee commenced its inquiry on Wednesday 19 January 2011 with an inspection of the site of the proposed works. The Committee then proceeded to the Day Centre Room, Flinders Island Multipurpose Centre whereupon the following witnesses appeared, made the Statutory Declaration and were examined by the Committee in public:-

- Maribeth Harris, Acting Area Manager, Primary Health North
- Sophie Legge, Primary Health Coordinator North Esk
- Barry Herberts, Director of Nursing, Flinders Island Multi Purpose Centre
- Bill Cochrane, Manager, Major Projects, Asset Management Services, Department of Health and Human Services
- Scott Curran, Director, ARTAS Architects

The hearing commenced with the witnesses outlining the need for the project. Flinders Island is a small community with a population of less than 1000. The island is remote and many services come from mainland Tasmania. The facility is currently a multipurpose centre and the future direction is for the development of multipurpose services to achieve more flexibility with services and funding which is sourced from both the Commonwealth and the State.

The Committee observed that the original project brief was prepared in 2001 and given the lengthy time lapse wanted to know if that date was accurate and the history of the development of the project:-

*Mr COCHRANE - I think it was. As this report says, the department, predominantly through Asset Management Services and Primary Health, could see that there was a huge issue with our rural facilities and the condition they were in. So we put together a generic brief for a lot of our primary health care facilities, our rural facilities, about what we thought they needed to do, and that was to have that combined inpatient, allied health and primary health focus. Then, of course, each hospital or facility we have until its redevelopment has discrete requirements and so a project-*

*specific brief for each of those projects was developed to make sure the outcome meets the needs of the local community.*

**CHAIR** - *So it has been a fair while coming, then, given that original project brief was developed back in 2001?*

**Mr COCHRANE** - *It has. King and Flinders will be the final old district hospitals to be redeveloped. Since 2000 we have redeveloped all of the old district hospitals, as they were known.*

**Ms HARRIS** - *So it has been a staging process around priorities for all of our rural district hospitals to become multipurpose services and centres.*

**Mr BOOTH** - *But the design is contemporary now? It is based on today's data rather than 2001?*

**Ms LEGGE** - *Yes. It was when Primary Health was in its own entity and the big regional hospitals came under Hospitals and Ambulance that Primary Health really looked at their facilities across the State and started planning for their upkeep and maintenance. We have just come to end of that time and of course we have flipped back into the regional again. Thank goodness we've all updated - we're happy.*

Mr Cochrane described how the design evolved:-

*At this point in time we have a design that is compliant with all the required standards - Building Code of Australia, aged-care accreditation, GP standards for consulting rooms and meets the Australasian health guidelines for health-care facilities, but the design wasn't developed in isolation. There was a lot of communication with community and stakeholders.*

Mr Curran, the architect elaborated:-

*As you have heard, there have been a number of issues with the existing facility and one of our primary objectives was to address all of those problems that we have but also be able to do those economically, so we have broken the building down into a number of different zones to enable us to be able to achieve this. One of the other issues we spoke about on the walk around was the need to have an easily identifiable entry and it was felt that entry should be off Davies Street directly opposite the Council Chambers, and because of the level access that we have from that entry that has determined the level of the building. It has been very evident from the walk around the number of different levels that are associated across the facility and a modern facility needs to operate on one level and that is one of the reasons we have chosen Davies Street to enable us to be able to do that.*

*We also needed to be able to separate out some of the services so that they could operate independently so that the whole hospital was not open 24-hours a day, and we are able to close down some of the areas that could operate independently. It was also very important for us that the ancillary*

*services could operate independently away from the rest of the facility as well and that access to that area was easy to get to and did not affect any of the operation. It was also important for us that the aged care area, whilst being functional and efficient, still maintained a homely appearance and also was warm and inviting. These are some of the things that have determined our response to the issues in the brief we were given.....*

*.....we now have a separate entry for the doctors and the specialist areas. This now enables the doctors to be able to operate independently and the specialists as well. It also enables this area to be closed down and operate independently. We have addressed the issue of patient confidentiality with a private waiting room and a reception area through there. ....*

*.....we have a discrete and private waiting area which addresses the need for privacy and separation from the main waiting areas through the rest of the facility.....*

*.....We have created a new community meeting area which doubles the size of this existing facility*

He went on to describe the improved, private location of the ambulance bay, the nurses station with good visual access to both the acute beds, the aged care area and the main entry. The Committee asked about the adequacy of the design and if there were any shortcomings. Mr Curran stressed the flexibility of the design and the construction techniques which allowed for that flexibility and future changes. Mr Herberts supported the design process and outcome:-

*During the planning phase - and obviously Sophie and I, as health professionals, have been part of all of those - we have been putting all sorts of ideas forward and they have all been addressed and made up into the plan so I think from my perspective, I would be quite happy to work in this facility. I think it covers all bases and all clinical scenarios have been addressed in the planning phase so, as a clinician and a nurse, I think it is a good facility and everything we put forward has been addressed in the plans.*

Ms HARRIS added:-

*The other thing I would say is that this is Sophie's fourth redevelopment so she has gone from one and added and changed things in other redevelopments that perhaps have not quite worked so well from that perspective so she really has that clinician rapport.*

**Ms LEGGE** - *It has been a really good learning process going through the different developments and picking really good things that staff have said a year later 'that is the best thing' - such as the lifting frames, whereas they ooh-aahed when we first put them in because they had never used a system like that. The rest of the hospital now from the aged care, for instance, at Scottsdale, it was not put into the acute end and the acute end is everywhere now. That becomes best practice and those are the sorts of things we have been able to inform straight into Flinders which has been really fortunate.*

The long term requirements of the proposed facility and the appropriateness for the island population were questioned by the Committee. Ms Legge again responded:-

*I think with the population that we have on Flinders Island - and it has been fairly stable - yes. The flexibility will come in the way that we provide services into the future. People like to stay in their homes a lot longer and we tend to find that residents do not come into our facilities until a lot later, until they are very high-need, whereas if we go back probably even 15 years ago they were coming in a hostel environment and then ageing in process. Now we find that they do not actually come in because we can do a lot more service provision within the homes now and outreach to people and provide that understanding of wellness earlier on and obviously you live longer and healthier. That is the plan.*

The witnesses emphasised the flexibility of the design and the changes which were being implemented in service delivery for better health outcomes. Mr Herberts noted that:-

*.....also a way to move forward with healthcare delivery and primary health is to try to address some of these problems in-home and put the services in their own homes. They are in familiar surroundings, family are aware of that, as opposed to uprooting them and bringing them into a clinical facility where you try to make it as homely as you possibly can but it is still a clinical facility.....*

Mr Cochrane in supporting the design flexibility said:-

*The other aspect of that is that all the inpatient rooms as they are designed at the moment give us the flexibility for aged care. We can accommodate high-need aged-care patients in all of those rooms.*

Mr Curran described the aged care area as follows:-

*We have some double doors there so that we can seal that aged-care component off. We have a patient lounge where patients can sit and watch television. We have a number of tables around there where they can sit and interact. Directly across from there we have a patient dining room. We have large sliding glass doors in all of those rooms that enable vision from the patient lounge, through the patient dining area and into the courtyard, which is accessed by staff and also by patients. You will see from the courtyard there is a ramp that comes down into the garden and that garden is secured by a pool fence that runs around the outside so that patients are able to leave the facility, go into the courtyard, go down into the landscaped areas and be in a safe and secure environment.*

*We have located all of the beds in one corridor. Each of those beds has an overhead lifting rail to help with getting patients or residents out of bed. We also have en suites off each of those bedrooms that comply with the current code. They are a little larger than they are required to be so that they can accommodate changes in the code over the coming period of time and also to enable lifting machines that may need to be taken into there. Each of those rooms has access out onto a balcony. One of the key considerations of this*

*was to enable each of those residents to have a view back towards the mountain or into a garden but also to have good solar access into those rooms so that they stay light and warm while they are able to during the day.*

Mr Booth asked whether there would be enough aged care beds in the future and put the following scenario to the witnesses:-

*I was wondering whether there will be adequate aged-care beds, for example. I do not know the population demographic here well enough to be able to say whether you are going to have that problem but because it is a small island you cannot share resources as you were saying before and you cannot just shift someone off to another hospital. Those sorts of things obviously are pretty critical and I am sure you probably have considered them but I just need to understand myself whether all that has been fully factored in. Although you do not have an inordinately large ageing population because of the stability of the place, if suddenly you find that you have a lot of older patients who require beds, both in the hospital part and the aged-care part, is the building designed to accommodate that?*

The Committee was assured of the potential for accommodating any increase in aged care patients by Ms Legge:-

*We have not had a huge waiting list ever really on Flinders Island for aged care and at times if you have one waiting placement they certainly come into our acute beds that are not full either. Our beds are there for 'just in case' and to give the community respite. You would probably on average have 10 admissions a month here into those four beds and they would come for a day or two or a week maximum, so there is flexibility for overflow, plus now with the addition of the bed.*

*Around diabetes and things like that, it is more about early working with communities on maintaining a healthy approach to life, getting out and walking and so on, so it is about engaging communities in those sorts of activities and that is why we can actually engage staff education around how we promote that, how we sit with groups within the community and help them work together on how they might look after their diabetes.*

*We also have GP North that we work closely with and they have diabetic educators who come out and work with the doctors their clients to try to maintain a healthy outcome for them so that they are living healthier and well.*

It was explained to the Committee by Ms Harris that:-

*When there are patients with complex care needs the outreach support comes from the Launceston General Hospital through education, through Telehealth, through sending a staff member over to educate staff here so we are on an as-needs and individual basis. There is a lot of resource put around individual needs.*

The Chair inquired about the current status of the Telehealth equipment given the fact that Flinders Island is an isolated community and has need for the technology on a regular basis. The exchange between the Committee and witnesses highlights the need and importance of Telehealth in the area.

*Ms LEGGE - We upgrade them as they are needed - that is ongoing - and we have just upgraded the one on Cape Barren Island last year because we were having problems with that one.*

*Ms HARRIS - This one is much less cumbersome than what was here before.*

*CHAIR - Is the current system meeting its purpose and likely to into the near future?*

*Ms HARRIS - From this end, yes.*

*Ms LEGGE - They have gone from an almost three-phase power set-up originally to now where you can put them into any computer socket basically, which means they are really flexible. We can move them into patients' rooms and into different rooms around the building, where before we were very keyed into where it was put in the beginning and that is where it stayed, but now we can move them anywhere.*

*Mr HERBERTS - The cupboard behind you, the grey one, is our old Telehealth cupboard and we have gone from that to that machine there. I occasionally have it in my office to have videoconferencing and we can do that in a number of areas. Our new facility will have access for that machine in all areas.*

*Ms LEGGE - We have certainly been mindful about the staff spaces so we can pull those into the staff spaces now and utilise them for staff education and things within their environment without taking up the room like this, which would be a community space. That has been wonderful and we have done that in our other facilities already that have been upgraded; we have that capacity now to just wheel it, which is really good.*

*Mr BOOTH - Would you like to expand in regard to this end of the Telehealth circuit?*

*Ms HARRIS - We are looking at ways where we can have medical specialists on the other end and working in different models of health so that our GPs have access to medical specialists with the patient involved, so there will be a lot more Telehealth and videoconferencing.*

*Mr BOOTH - Is that currently an impediment to your utilisation of it?*

*Ms HARRIS - No. We use it with the diabetes educator and Barry talked about the LINC person. We have LINC people in all our sites. The diabetes educator runs education and support sessions for all the LINC people so we*



*use it a lot through education and through meetings. As to the Telehealth side of it, we are looking at ways we can get better utilisation of it.*

***Ms LEGGE** - Our rural facilities have used Telehealth now for over 10 years so we are really proficient in it. I would say probably over half of our communities are across where we link up six, seven and eight sites together and we will have a meeting regularly each month like that. It is about engaging our big regional hospitals. They are not into that mode yet. They have not needed to be as they are self-sufficient, but because we are not and are limited in the way that we can educate staff, if you take two or three staff members out of any rural area you suddenly have an issue of how to staff on the ground or how you backfill and things like that. So for us it has been a fantastic medium for education and bits and pieces like that. We are now starting to use it more and more for patients but we do find it is really hard to get the specialists at the other end because if they are working in that busy LGH environment to go into another room to do Telehealth would be an issue for them. So we are looking at ways at our end and that is why Maribeth is talking about the other end where we can get it on their laptops and they can do this now so that they do not actually have to leave their rooms anymore, they can do it by laptop.*

***Ms HARRIS** - And the resolution of zeroing into the wound or whatever and then being able to send all the pathology data. Certainly the CEO of the Northern Area Health Service is very committed to advancing electronic media wherever he can.*

***Ms LEGGE** - We are taking them into our accident and emergency areas and having that link-up while we are waiting for air-lifting out and things like that. That has been a huge benefit where they can actually see the client at the other end. It is good. But it is, as I say, getting them involved in that and understanding how important it is for us to do that.*

The Committee asked about the use of local contractors and tradesmen and were informed that the matter was being investigated.. Mr Curran outlined the situation thus:-

***Mr CURRAN** - The most likely scenario will be that it will be a contractor from mainland Tasmania because of the pre-registration that is required. They will need to be pre-registered for a project up to \$6 million. The contractors that we have been talking to to gauge interest in this project have mentioned that the most likely scenario would be that they would utilise some of the existing resource on the island - things like project management or carpentry or whatever. But obviously it is in their interests to use people on the island because it is cheaper than flying people in but obviously there is a restricted resource on the island.*

The cost of flying people to the island was also canvassed and the Committee was told that there was a remote allowance of \$1.2m factored into the cost estimates to allow for the location:-

**Mr CURRAN** - Yes, it is \$1.2 million. So it is quite a bit more than King Island and that really is the thing that is the unknown at the moment, given that our industry is in a slow-down, contractors are becoming a bit keener.

As the schedule for the redevelopment is over an eighteen month period the Committee inquired about additional accommodation and the necessary re-location of hospital services while building was in progress Ms Legge said:-

*The community is really obliging because obviously the outcome is huge for them, to get a new facility. We find that by working with council and other stakeholders within the community it is amazing what you can rally up. We have Housing Commission homes - there are three rooms there that haven't been used for a long time and we're looking at using those to put community nursing and other allied health people in. We would not need four beds for a period of time and we'd slowly bring those areas down. In George Town, which is a 15-bed facility, I think we went down to eight or nine beds for a while. LGH is very aware of that so they would keep a client for longer while we're doing that. You tend to be flexible in the way you move people around. People make do with a small desk space in the outcome of knowing what they'll have in the end.*

**Mr HERBERTS** - I think the way the stages are being planned is that this is stage one, so this is basically a non-clinical area, apart from the GP surgery, so this is going to be built up into the inpatient facility so we can keep our current inpatient facility intact. Once this is finished and commissioned, we can then bring our residents and patients into the new facility. That has been taken into consideration in the planning phase.

The submission included the various sustainability features to be incorporated and the Committee noting the use of peak energy demand reduction. asked about the introduction of environmentally friendly system generation and other allowances for renewable energy. Mr Cochrane and Mr Curran explained the features incorporated in the plans and answered further questions:-

**Mr COCHRANE** - We haven't pigeonholed specific amounts, we just expect that our consultants, as part of their judicious design process, will give us some good-quality environmentally-sustainable design factors. I think you have come across Mr Cooper from Asset Management Services in your discussions on King Island. Greg is a mechanical engineer who is very strong on energy management. He is a green star professional. We will be looking to see if we can key into some programs that have been made available to perhaps look at some supporting wind generation and some other issues such as that. Not so much solar - for a large commercial building the cost of that outweighs the return. If we can look at some sort of wind generation, we will be trying to factor that in.

**Mr BOOTH** - You would have solar hot water and double glazing and so forth?

**Mr CURRAN** - We have 10.38 laminate on the windows, which will add to the thermal massing of those rooms. We are putting insulation into walls and ceilings. The orientation of this building is a lot better. We are creating spaces where you are able to open the windows without the whole room being blown out. There are lots of little things that we are doing to aid that, without putting in the big bangers such as wind-powered turbines and all those things. We have potable water that we collect off the roof that is reused for drinking. We are using the town supply for flushing the toilets. We are being as environmentally friendly as we can, taking the things into consideration that we do have budget constraints with what we're trying to do. We are trying to put those in - low-energy light fittings and all those sorts of things are going into our buildings as standard practice now.

**Mr BOOTH** - Will you have a star rating that it will meet?

**Mr CURRAN** - No, we haven't done a green star rating back on this building.

**Mr BOOTH** - Will that happen?

**Mr CURRAN** - No, we are not getting the building green star-rated but we are using a lot of the ideologies of the green star rating system throughout the building.

**Mr BOOTH** - So if you just go back to the window issue again - you are using comfort glass or something are you, rather than double glazing?

**Mr CURRAN** - Yes

**Mr BOOTH** - I think on King Island you were going to use double glazing over there for all the windows?

**Mr CURRAN** - Yes, there is a lot less window replacement over there though than we have here. So the 10.38 gives us performance nearly equal to the double glazing and when you consider the cost implications of going from the double glazing to the 10.38, you really cannot justify the cost difference against the benefits that you get using double glazing against the 10.38.

In his opening comments Mr Cochrane noted that at this stage there were insufficient funds allocated for the project. He said:-

*We have a budget shortfall at this point in time that we will manage from within the department, as we have with a number of projects that we've had in front of the committee, so we haven't constrained the design to the dollars that were available. We appreciate the logistics of doing a redevelopment in a remote community such as this so we are very much of the opinion that we do it once and we do it right. If that means that we have to find some other dollars to get the outcome that's required, we think that is eminently more sensible than trying to cut things off and having to do it again at a later date where it is going to cost us more money for another tender process and re-*

*establishment of builders and such. Of course there is a sensible envelope that that is undertaken in - there are no extravagances or that we build a facility that is larger than what we actually need.*

The Committee asked about opportunities to find the extra funds required and if the shortfall would have to come from other budgets. Mr Cochrane again:--

*Mr COCHRANE - Not necessarily, until we tender the works and get the appreciation of the industry of what they see it is going to take to build this building on Flinders Island, we will not know whether we have a budget shortfall or how much that budget shortfall will be. One of the first things that we will do when we have a successful contractor is lock ourselves in the room with them and their subcontractors and go through a value engineering session and go through the specification, line item by line item, to see whether we can identify any savings. If that is not successful within the department, we have an expansive capital program and some projects, believe it or not, we bring in under budget. So with the proper approvals through the department and Treasury we can transfer funds within projects.*

*The other avenue that is available to us is asset sales. If we relinquish an asset and it is no longer required by the department, we can sell it - we did that recently after we built the Smithton District Hospital. We had two facilities that we were able to sell and they were in the business district and realised a reasonable return on that money. That money comes back through Treasury and because the department has an approved strategic asset management plan, we get a minimum of 75 per cent of that money and that money is then put back into general revenue within the department to be reinvested in service delivery initiatives and that comes back through asset management services, the branch that I work with and, again, in discussion with the department, we see if we can reallocate that to the point of greatest need.*

When the possibility of a budget worst case scenario was canvassed and additional funds were not available Mr Cochrane answered:-

*From my perspective I am highly confident that we will secure additional funding if it is required. This has been discussed right through our chief financial officer up to the minister's office, it is not me sitting here in isolation and saying that is the issue. It is an issue we have had with remote location with the Queenstown project and new hospital there. We had a budget shortfall and we presented it to the Parliamentary Standing Committee and at that point in time we were anticipating about the same sort of amount, about \$600 000 to \$700 000. When we did get the tender it came in at \$1.6 million. It was just what the industry was demanding*

**Ms WHITE** - Over?

*Mr COCHRANE - Yes, over - to build in a remote location like Queenstown. One of the issues they had was getting staff who wanted to go to Queenstown and work through the winter around there so they were*

*having to pay over the odds of the salary costs that we would normally expect. What we have actually found on Flinders is that this is a very desirable location to come to and people are keen to come here and work here for 12 or 18 months. And the same sort of thing again we were presented with a significant budget shortfall that we had to cover off and again we will undertake value management sessions, value engineering and look for any sensible cost cuts that do not affect the required outcomes to manage that cost.*

## **14. CONCLUSION AND RECOMMENDATION**

The need for the new facility was clearly established and evident to the Committee during the course of the inspection and the hearing. The design for the Centre has been developed to allow for any unforeseen changes and is adaptable should circumstances arise to necessitate modifications. The importance of suitable accommodation for GP, specialist and other allied health services has been acknowledged and sensitively incorporated into the project design. A shortfall in funding has been addressed and the Department is confident that there will not be any difficulty securing the necessary additional funds.

Accordingly, the Committee recommends the project, in accordance with the plans and documentation submitted.

**Parliament House  
Hobart  
2 March 2011**

**Hon. A. P. Harriss M.L.C.  
Chairman**